"THE EFFECT OF CLIENT'S RACE/ETHNIC STATUS AND LEVEL OF ACCULTURATION, AND THE INFLUENCE OF PRACTITIONER CHARACTERISTICS, ON SOCIAL WORKERS' CLINICAL JUDGMENTS"

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ABSTRACT

THE EFFECT OF CLIENT'S RACE/ETHNIC STATUS AND LEVEL OF ACCULTURATION, AND THE INFLUENCE OF PRACTITIONERS CHARACTERISTICS ON SOCIAL WORKERS' CLINICAL JUDGMENTS

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This study examined whether social workers' clinical judgments reflect differences in the client's level of acculturation; or whether their judgments are influenced by the client's race/ethnic status, ignoring important differences in the client's level of acculturation. This study also examined whether the practitioner's race and years of clinical experience moderate these clinical judgments. Finally this study analyzed patterns of differences in the clinical judgments between various racial/cultural/-ethnic client groups.

The primary statistical procedure used in this study was the univariate (mixed-model) ANOVA for repeated measures (mixed-model) designs. The instrument used in this study consisted of sets of questions (The Cross-Cultural Clinical Judgment Inventory), requiring the respondent to make judgments (perceived importance of cultural/ethnic issues) about eight analogues. Two analogues per ethnic group (i.e. Black, Puerto Rican, Polish and Jewish) were provided. The CJI scale had excellent internal consistency reliability,

with Coefficients alpha ranging from .92 to .96 for each of the eight analogues.

Results suggest that social workers are sensitive to the client's level of acculturation in their clinical judgments. However, specific comparisons <u>within</u> each of the ethnic group analogues reveal that this is not the case across all client groups. That is, there was an inability to distinguish between levels of acculturation within the two Black family case vignettes.

The analysis also revealed that the practitioner's race did not have a significant effect on clinical judgments. However, the practitioner's years of clinical experience did have a significant effect on clinical judgments.

Finally, this study revealed significant differences between (high acculturated) racial minority and White ethnic family analogues; results were not significant with low acculturated analogues.

The finding that the level of acculturation is not differentiated within the Black family analogues provides some empirical evidence to question whether Blacks are seen as a homogeneous group, and if ethnocentrism and stereotypical assumptions cloud systematic differential clinical decision making.

This study also implies that highly acculturated racial minority clients are more at risk of being overassessed with reference to the assumption of the importance of cultural issues, and thus inappropriately served.

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Dedication

This dissertation is dedicated to the memory of my father, the late Mr. Johnnie Matthews, Sr. (1913-1985.)

He spent the better part of his life struggling to provide access to quality education for his children, to enable them to combat the forces of racism and poverty.

Chapter One

The Research Problem
(Origin, theoretical considerations and problem statement)

ORIGIN

The concern for rendering culturally "sensitive" and culturally appropriate counseling and social services has become of paramount concern to social work and other helping professions. Available research provides extensive empirical support for the need for further research, as well as retraining and program planning in this area of concern.

For instance, massive stereotyping, discriminatory practices, high drop out rates and evidence of ineffectiveness have been documented in clinical research studies focusing on diverse ethnic and racial client populations (Stanley Sue, 1977; Craig and Huffine, 1976; Flester and Rudestam, 1974; Abramowitz and Murray, 1983; Griffith and Jones, 1979).

In spite of these disturbing findings, empirical studies of practitioners that focus on cross-cultural clinical issues are quite sparse. More specifically, research attempting to define and measure "cultural effectiveness" in clinical judgements is practically nonexistent. There is no satifactory instrument for measuring the criteria of defining cross-cultural sensitivity and effectiveness in clinical judgements.

A review of the clinical research literature on cross-cultural issues clearly shows that there is no systematic development of method, no uniform theoretical basis and no agreed on outcome criteria (Pedersen, Draguns, Lonner and Trimble, 1983). Therapy, counseling and clinical judgements are complex enough to study; however, when one adds vaguely defined variables like culture and acculturation, it becomes even more complex. The complexity, no doubt, is part of the reason for the rather weak research response to the challenge.

This study is an attempt to repond to the research challenge of developing more uniform theory, outcome criteria and systematic methodology for defining and measuring cross-cultural sensitivity and

effectiveness in clinical judgements. Furthermore,this study attempts to develop and validate a scale that measures sensitivity in clinical judgments to cultural issues across various racial/ethnic/cultural client groups.

THEORETICAL CONSIDERATIONS

Scholars in the cross-cultural counseling field predict a paradigm shift, in the "Kuhnian" sense, from race to culture in the near future (Johnson, 1982). More attention in counseling has been drawn to the concept of culture, as opposed to the narrower concept of race. We are beginning to realize the limitations and drawbacks in using the concept of race as a guiding construct in making differential clinical decisions, rather than using the broader concept of culture. "At the heart of what seems to be emerging in this area of applied social science is a reframing of a previously race-based approach to defining the boundaries each of us cross in our daily social interactions" (Johnson, 1982).

On one hand, the concept of race (a largely biological concept) appears to be nothing more than a typological attempt to classify genetic and

phenotypical frequency distributions of biological characteristics, neither a very sophisticated nor particularly relevant dimension on which to base clinical decisions regarding social behavior. On the other hand, the concept of culture, is a more comprehensive and inclusive concept than that of race; therefore, potentially, a more valuable concept to use in making differential clinical assessments and interventive decisions. For example, locating the client within his own specific sub-culture gives the practitioner information about the client's social class, ethnicity, race, national origin as well as geographic origin. More importantly, locating the client within his own specific sub-culture via the concept of acculturation can provide further insight into clients' behavior.

Though the concept of culture is inherently a more comprehensive concept, and therefore potentially a more useful concept than that of race, it is also necessary to make clear that the use of stereotypical assumptions regarding the client's culture can also lead to misjudgments similar to the sole use of the

concept of race in making differential clinical decisions. Therefore, the clinician's task is more than merely locating clients within their specific sub-cultural spectrum; the need is to attend to this information in a non-stereotypical fashion.

A secondary purpose of this study is to address the problem of mechanical and sterotypical clinical judgments by developing a method to empirically assess whether clinician's attend to specific sub-cultural information (i.e., level of acculturation) and thus use the larger concept of culture, or if the narrower concept of race is utilized as a guiding construct in clinical practice.

The task of assessing and designing services that do not violate or dismiss important cultural variables has often been thought of as a concern only relevant to practice with racial minority groups (i.e., Asian, Black, American Indian, and Hispanic.) However, as the social work field (and related disciplines) become more sophisticated in its conceptualizations, and as the shift from a concern with race to more emphasis on culture continues and grows, this dilemma has and will continue to broaden from being merely a

black/white issue, lower class client concern, or new immigrant issue to include White ethnic groups. Understanding the client's <u>specific</u> sub-cultural background and understanding the parameters on which culture varies, and how culture influences client behavior, will clearly be seen as a relevant concern for all clients, regardless of racial or ethnic (majority/minority) status. Thus, the issue of cultural effectiveness should become a relevant concern for every client. Thus, this project, as a secondary focus, seeks to develop appropriate methodology for analyzing "cultural effectiveness" in clinical judgments for all clients, regardless of racial or ethnic (majority/ minority) status.

The shift from race to culture in the cross-cultural counseling field, has caused more attention to be drawn to the variables of acculturation and assimilation in the clinical context. It is thought that clients may receive poor services if their level of acculturation is not adequately considered. However, not all clients from identified racial minority groups need a specially tailored service plan, based on cultural variables.

Assumptions that all racial minority clients will require special "culturally tailored" interventions may lead to an overassessment of cultural phenomenon. Secondly, it can lead to assumptions that "majority" White, or White ethnic clients will not require any tailored, cultural interventions, resulting in the underassessment of cultural phenomenon, or overlooking of critical cultural varibles. For example, the highly acculturated individual (regardless of race or ethnic status) whose life style and values, etc. are similar to those of other "mainstream Americans", may be inappropriately served if given differential type treatment.

This framework is not meant to promote discriminatory service or differential treatment merely based on sub-cultural backgrounds. Rather, it is assumed that differential services are not inherently poorer, inferior, or less preferential services. Differences in intervention should provide a "fit" between service plan and the client's life-style (Sue, 1977).

The conceptualization, that directs this study, of a culturally effective counselor, is one who can

filter through client characteristics such as race, social class, level of acculturation, ethnic and cultural background, and avoid ethnocentric, prejudicial, racist and stereotypical notions about the client. This perspective does not suggest that the clinician dismiss these characteristics but rather is able to emphasize salient cultural variables. Furthermore, it becomes the clinician's task to study pertinent cultural information on all clients, regardless of majority/minority status, rather than making automatic assumptions regarding the relative importance of specific cultural information. The relative importance, that cultural information has in any particular case, depends to a great extent on the degree of acculturation to the larger dominant American culture that the client has acquired.

In summary, it is important to actively consider cultural phenomenon in all clients, then to render clinical decisions and implement "culturally tailored" interventions in those cases where the degree of acculturation indicates that these considerations are warranted. This is a dramatically different conceptual framework than the use of client's race as

a basis for clinical decisions. It is also quite different than using the ethnic/racial/cultural background of the client in a mechanical and stereotypical fashion. The preferred conceptual framework would be the practitioner who uses the concept of culture in giving special clinical considerations by plotting the specific sub-cultural background of any client, including the degree of acculturation, and who then renders clinical decisions based on this process. This allows for important cultural phenomenon of the majority White or White ethnic client to be adequately considered, as well as avoiding mechanical processing of racial minority clients.

In line with the shift, from race to culture, and the emerging concern of cultural issues with respect to groups other than racial minority clients, this study seeks to analyze the practitioner's sensitivity across various racial/ cultural/ethnic client groups. Furthermore, patterns of overassessment and underassessment with respect to cultural phenomenon will be analyzed by studying whether clinicians' decisions misjudge the client's level of acculturation

or if decisions indicate stereotypical assumptions about the client's race/ethnic status.

PROBLEM STATEMENT

This project seeks to study whether social workers' clinical judgments reflect the differences in the client's level of acculturation; or are their decisions (mechanically or stereotypically) influenced by the client's race/ethnic status, essentially ignoring important differences in the client's level of acculturation. This project will also study whether the practitioner's race and years of clinical experience moderate these clinical judgments.

Finally, this study will analyze patterns of differences (if any) in the clinical judgments between various racial/cultural/ethnic client groups.

As cross-cultural training approaches are developed more widely and implemented more aggressively at various schools of social work and in staff development training programs, it will become of vital importance to educators and training personnel to have available criterion for defining, and a method for measuring, aspects of cross-cultural "sensitivity" and effectiveness with diverse ethnic, cultural and

racial client populations. The procedures developed in this study are potentially useful as one indicator of effectiveness (i.e.,ability to distinguish level of acculturation) in the empirical evaluation of outcome in cross-cultural clinical training programs.

Chapter Two

Literature Review

(Relevant theory, related studies and prior work)

RELEVANT THEORY

Stanley Sue (lecture, 1981) advocates the use of "degree of acculturation" as a critical criteria in discerning when culturally "tailored" services are needed. He has outlined four different styles of service delivery that may result in inappropriate or appropriate services. An outline which illustrates how the provision of "differential" or "similar" services can result in both good or poor treatment outcome is presented below:

	Good Outcome	Poor Outcome
Different Service	Culture Fit Model	Discrimination Model
Same Service Model	Acculturation Model	Faulty (everyone is the same)

In essence, this outline indicates how different treatment outcomes can be derived from rendering clients' services that are culturally tailored to fit special needs or from rendering services that are similar to those services that would be offered to "highly acculturated mainstream Americans."

In summary, the four models of service delivery are:

1. Culture Fit Model
   - "culturally tailored services" are designed to suit clients who are not highly acculturated and/or assimilated
2. Discrimination Model
   - these are differential services, less preferential treatment, that are the result of racist and/or ethnocentric attitudes (the result is poor outcome)
3. Faulty (everyone is the same) Model
   - similar services are provided to everyone, based on an inability of the service provider to discern when special, culturally tailored services are needed
4. Acculturation/Assimilation Model
   - specialized "culturally oriented" services are not required, based on an assessment of the degree of acculturation.

RELATED STUDIES

The clinical research literature reveals disturbing empirical evidence of ineffectiveness with diverse ethnic and racial client populations. For

instance, documentation showed that discriminatory practices characterized the services to "minority group" members, which then proved to be ineffective. Findings indicated that minority patients (Chicano, Black, Asian) had a higher dropout rate, and/or were discharged more quickly, seen more often for minimal supportive counseling rather than psychotherapy or group long term therapy, and tended to receive the more severe diagnosis (Stanley Sue, 1977).

Other clinical studies have revealed similar results that suggest massive stereotyping and discrimination as probable causes for ineffectiveness (Abramowitz and Murray, 1983). Clinical issues, diagnostic ideologies and organizational factors no doubt serve to inhibit and undermine culturally appropriate service.

Ethnic "specialty" clinics, expert culture consultants or mediators and cultural "sensitivity" training approaches have been devised to improve counseling services to diverse ethnic and racial client populations. There is little or no empirical evidence to support the relative success or failure of any of these approaches.

Empirical clinical studies of practitioners that have dealt with cross-cultural clinical issues are

quite sparse, as previously noted. The bulk of the studies done, to date, have not specifically dealt with the problem of defining and measuring culturally sensitive clinical judgments. Nor have any of these studies revealed any data concerning practitioner variables.

These studies have tended to focus on interactive difficulties in cross-cultural interviewing, with very little emphasis on clinical decision-making. These studies include: basic communication difficulties and bias in interviewing (Carkhuff and Pierce, 1967; Williams, 1964); psycholinguistic barriers in evaluation (Marcos and Alpert, 1976); under-recording of symptoms (DeHoyos and DeHoyos, 1965); differential response patterns on screening instruments (Gynther, 1972); significant diagnostic errors (Simon et al., 1973); arbitrary criteria for emergency care (Peske and Winthrob, 1974); misinterpretation of psychodynamics (Thomas, 1962; Warren, Jackson et al., 1973); violation of cultural norms (Abad, Ramos, Boyce, 1974; Lombillo and Geraghty, 1973); failure to comprehend differences between culturally adaptive and maladaptive behavior (Gilbert, 1974); and discordant perceptions of patients and therapists, and the

patient's desire to continue treatment (Kline, Acosta, Austin and Johnson, 1980).

The most notable clinical studies on cultural issues have been conducted by Lefley (1981) and Pederson (1981). These two studies attempt to evaluate intensive cultural training efforts. Each of these training and evaluation efforts primarily focused on assessing changes in the cognitive and affective levels of the trainees with minimal attempts to ascertain behavioral outcome measures on actual clinical judgments. What these research/evaluative efforts do indicate is the need for research on the actual clinical judgment process, and that there is an on-going need for combining research, service and training into an interlocking loop feedback system.

In 1979, Lefley's cross-cultural training institute was organized and included an eight day training workshop. The project evaluation sought to identify changes in cognitive, social and affective distance, attitudinal distance in stereotyping, value differences, behavior effectiveness, training readiness, organizational sensitivity, and self descriptions of training outcomes. Research findings have indicated significant changes on self-report measures assessing levels of cognitive, affective and

social distance. Analysis of a behavioral measure, a videotaped therapeutic interaction, suggests improvements in cultural sensitivity as assessed by raters from the interviewer's own and contrasting cultures. Other objective indicators, reflecting minority utilization and dropout rates in trainee's client caseloads, showed similar trends.

If the preliminary findings (Lefley, 1981) continue to be confirmed in the long-term follow-up scheduled, there is some indication that even a short-term, but intensive, cultural training experience can have significant impact on basic conceptualizations, planning, and client's acceptance of services. Unlike the study reported herein no case analogues were utilized to study the actual clinical judgment process, and practitioner variables were not studied in relation to other outcome measures.

The DISC (Developing Interculturally Skilled Counselors) Project was funded from 1978-1981 (Pedersen, 1981). It combined a training procedure with evaluation measures to increase the facility of cross-cultural training for mental health professionals. The evaluation instrument consisted of four Likert-type items with a six-point scale surveying the participants' judgments of Helpfulness,

Interest, Importance, and Usefullness on each presentation. In addition, open-ended phrases enabled the trainees to self-rate gains in the areas of cognitive, affective and skills enhancement.

With at least one group of trainees, the critical incident approach was used. The trainees were asked to identify as many cross-cultural issues in the case vignettes as possible, as well as any value differences, and to comment on a course of action in each case vignette. Due to the nature of the small training groups, practitioner variables were not studied. Trainees were not selected with the intent to have a broad cross section of subjects in order to yield statistically significant or generalizable results along practitioner variables.

Evaluative results were very positive; however, self-rater type instruments have such a strong subjective component that one must be cautious of outcome measures. Regardless, with the use of the critical incident approach, this study represents the most rigorous and focused study of actual clinical decisions concerning cultural issues. A purposive sampling plan, control groups, and pre and post testing measures would have given the results much more generalizability and reliability.

In 1982, Pedersen developed a "triad" method for cross-cultural training. This model matches a therapist trainee from one culture with a coached team of two other persons from a contrasting culture, one as a client and the other as an "anti-counselor", for a videotaped simulation of a cross-cultural therapy session. The therapist seeks to build rapport with the culturally different coached client, while the anti-counselor seeks to represent the problem element from the client's cultural viewpoint. As in the case of the above-mentioned studies, research was focused solely on various affective and cognitive measures.

The focus in this dissertation is markedly different from the cross-cultural studies just cited; in that this project sought to study professional behavior rather than measuring increase in cultural knowledge or attitudinal shifts after training sessions. It is critical that we study measurable behavioral outcomes and establish theoretically consistent outcome criteria, as we begin to invest more resources aimed toward improving cultural effectiveness in counseling. It is important to keep in mind that even though attitudinal changes may occur and cultural knowledge is enhanced, as a result of education and/or training efforts, there is no

guarantee that these changes alone will translate themselves into improved clinical judgments (and outcomes) with reference to cultural phenomenon. Training must eventually be directed at the clinical process: i.e., assessment, intervention planning, relationship building, etc. In reality, improved outcomes for clients are the rationale for our efforts.

PRIOR WORK

Much of the earlier clinical judgment literature in the field of social work (Briar, 1961; Haase, 1964; Fischer, 1970) focused on the social class and race of the client, but did not address or control for practitioner variables such as race.

Previous analogue studies comparing clinical judgments of clients from differing social class and racial backgrounds found that practitioners ascribe more negative traits to lower class clients, when case situations and problems are identical, than to middle class clients (Hollingshead and Redlich, 1958; Rosenthal and Frank, 1958; Lorion, 1974).

Fischer (1970) conducted a study assessing the impact of client's race and social class on the clinical judgment process. However, Fischer did not study,or include in his design,the impact of the

practitioner's characteristics. Franklin (1985) did a follow-up study that did control for various practitioner characteristics. More specifically, she included in her design practitioner's race, years of clinical experience and theoretical orientation. She found significant relationships between these variables and clinical judgments - the current study also included the practitioner's race and years of clinical experience in the research design and analysis. The variable of theoretical orientation was not included in the analysis of this dissertation project due to the small cell sizes found in the various practice orientations. Franklin (1985) found a statistically significant relationship ($p = .01$) between theoretical orientation and race of the practitioner, indicating correlations between these two variables.

Briar (1961), Fischer (1970) and Franklin (1985) used race and/or social class of the client as the independent variables in their respective studies. This project uses race/ethnic status and level of acculturation of the client as the independent variables. Review of the literature failed to identify any study in which the level of acculturation

was employed as an independent variable in clinical research on judgments.

The significance in the substitution of the variable, level of acculturation for social class, is that this will allow for a closer examination of how social workers' clinical judgments are influenced by a key aspect of the more comprehensive concept of culture (i.e., level of acculturation within client.) In addition, important comparisons can be made with reference to the two concepts i.e., race versus culture, more specifically - acculturation, as guiding constructs in clinical practice.

Another significant difference between this dissertation and the Briar (1961), Fischer (1970) and Franklin (1985) studies is the inclusion of various racial/ethnic/cultural client groups in the case vignettes so that important within and between group comparisons (with respect to client's race/ethnic status and level of acculturation) can be analyzed.

Fischer's (1970) and Franklin's (1985) results showed that social class alone did not have a significant effect on assessment. Rather, they obtained an interactive effect between race and social class on assessment. As Fischer points out "high and low social class clients were not at all different

from each other - only the social class label was changed." Similarly, Franklin in her replication of Fischer's original study changed the race of the client, without an alteration in any of the details of the vignettes. Thus, it is not surprising that social class alone did not have a statistically significant effect on clinical assessment, in either of their studies.

Also not surprising is that results in both of their studies (i.e., Blacks were judged more positively than White clients) completely contradicted the vast majority of findings from clinical studies; which, almost without exception, have found that racial differences, with reference to Black and other racial minorities, exert a negative effect on actual diagnosis, assessment and treatment decisions.

The puzzling discrepancy between their analogue research studies and actual empirical clinical studies can possibly be due to the fact that only the client's race and social class labels were changed; and the verisimilitude of the analogues was seriously violated in not altering important details within the vignettes.

The case analogues featured in this research project deliberately varied the independent variables

and realistically reflected the subtle differences and complexities that these "labels" are intended to represent. This procedure is not without its own methodological issues. However, it is believed that many of these concerns can be allayed by the strict standardized procedures adhered to in the construction of case analogues. (These details will be outlined in the Methods chapter.)

Paul Pedersen (1981), a prominent cross-cultural researcher and theorist, strongly urges analogue simulation studies deliberately varying "culturally related" variables pertinent to the clinical context. Furthermore, Pedersen (1981) gives support to the questions posed in this dissertation project, in that he states, "one must go beyond the simple use of skin color or nationality in the study of clinical acuity".

Chapter Three

Design and Methodology

RESEARCH QUESTION(S) AND HYPOTHESES

The research questions in this study are:

1. What is the effect of the client's race/ ethnic status and level of acculturation on social workers' clinical judgments?

2. What is the effect of the practitioner's race and years of clinical experience on social workers' clinical judgments?

3. Are there significant differences in clinical judgments between various (racial, cultural, ethnic) client groups? If so, which variables (client and/or practitioner) are responsible for the differences?

4. Do social workers render differential

clinical judgments, given varying levels of client acculturation? And, if so, do they render these differential judgments across all (racial, cultural, ethnic) client groups? Are some practitioner's able to differentiate level of acculturation better than others?

The hypotheses in this study are:

1. Client's race/ethnic status and level of acculturation will have an effect on social workers' clinical judgments. That is, social workers' clinical decisions will vary according to the specific race/ethnic status of the client, as well as the degree to which the client is/is not acculturated to the dominant American culture.

2. The effect of client's race/ethnic status and level of acculturation on social workers' clinical judgments will be moderated by the practitioner's race and the years of clinical experience.

3. There will be significant differences in clinical judgments between and within various (racial, cultural, ethnic) client groups; these differences will also be moderated by the

practitioner's race and years of clinical experience.

VARIABLES UNDER STUDY

There are four independent variables in this study: two within-subjects factors, namely the client's race/ethnic status and level of acculturation; and two between-subjects factors, practitioner's race and years of post-M.S.W. clinical experience.

The variable of client's race/ethnic status has four indicators: Jewish-American, Afro-American, Polish-American, and Puerto Rican. Client's degree of acculturation has two levels: high and low/moderate. Practitioner's race has three indicators: Black, White and other. Practitioner's years of (post-M.S.W.) clinical experience has three levels: 0-3 years, 4-6 years and over 7 years.

The variable of years of (post-M.S.W.) clinical experience was included in the research design as it is hypothesized that as practitioners gain clinical experience through the years, they will become more "culturally sensitive" counselors (i.e., render less stereotypical clinical decisions) and more often will

be able to appropriately reflect important differences in the client's level of acculturation.

The variable of the practitioner's race was included in the research design as it is hypothesized that practitioners' personal experiences and ethnic background enhance their knowledge and understanding of the potent cultural process and thus their facility for rendering "culturally appropriate" decisions. The inclusion of these two variables was also influenced by the significant findings in the Franklin (1985) clinical judgment study, as previously cited and discussed.

The dependent variable in this study is clinical judgment, as measured by the Cross-Cultural Clinical Judgment Inventory (CJI). The CJI, which measures perceived importance of cultural factors in clinical judgments, was developed and used as a scale for analyzing the dependent variable. This variable has twenty (20) indicators combined into a summative scale. The twenty indicators are a comprehensive list of diagnostic, assessment, intervention, service planning and other relevant clinical issues that require consideration in the overall planning for the

client. (See Appendix A for a complete listing of these indicators.)

RELIABILITY OF INSTRUMENT

In order to establish the internal consistency reliability of the Cross-Cultural Clinical Judgment Inventory (CJI) scale, as administered under eight conditions (after each of the eight vignettes), coefficient alpha was computed (Cronbach, 1951). As shown in Table 1, the internal consistency reliability is adequate for each of the eight administrations of the measure. Coefficients alpha ranges from .92 to .96. Thus, the CJI is a unidimensional measurement tool, with excellent internal consistency reliability.

Table 1.

Scale Reliabilities, Means and Standard Deviations

Scale Name	Sample Size	Alpha	Mean	SD
Jewish (L.A.)*	130	.92	50.15	12.06
Jewish (H.A.)*	130	.95	39.52	13.50
Polish (L.A.)	129	.95	47.43	13.99
Polish (H.A.)	130	.96	38.81	14.41
Black (L.A.)	130	.95	47.79	13.88
Black (H.A.)	129	.95	45.47	13.87
Puerto Rican (L.A.)	129	.96	51.13	15.28
Puerto Rican (H.A.)	130	.95	46.88	13.71

*Note: The abbreviations, L.A. and H.A., indicate either high or low acculturated corresponding vignette.

RESEARCH DESIGN

The research design is a mixed-model analysis of variance (ANOVA), with a 2 x 4 (factorial) within-subjects design and a 3 x 3 (factorial) between-subjects design.

This study uses a repeated measures design - which involves each participant being measured 8 times, the eight case analogues, on the same dependent variable (the Cross-Cultural Clinical Judgment Inventory.)

The research method is a (non-experimental) cross-sectional survey using a mailed questionnaire.

SAMPLE

A disproportionate stratified random sample was selected. Practitioners from racial minority backgrounds were "over sampled", in order to have these groups adequately represented in the sample.

The population of interest was social workers who are members of the National Association of Social Workers (N.A.S.W.) This population was selected because of the uniformity in professional and educational standards adhered to, as well as a pragmatic consideration of the availability of mailing lists of members, and knowledge of important

population parameters ,such as percentage of racial minority members.

Additional considerations included the diversity of fields of practice represented within N.A.S.W. as well as a heterogeneous sample available, with reference to years of experience and race/nationality (moderator variables under study in this project.) The above factors were considered desirable, given the intent to generalize the results of this study to a professional population of social workers.

The sample used in this study was the members of the Chicago area chapter of N.A.S.W. This sampling frame was seen as reasonable, given the need to sample practitioners who, probably, have had exposure (personal and professional) to diverse ethnic groups.

B.S.W.'s were systematically differentiated from M.S.W.'s and professionals with advanced degrees - as respondents were asked to indicate the number of years of post-M.S.W. clinical experience. However, M.S.W.'s and advanced degree clinicians were not differentiated in this study.

A mailing list of Chicago area N.A.S.W. members was provided by the Illinois Chapter office, including a special mailing list and breakdown by race/ethnicity

of members. The mailing list consisted of all persons who had joined N.A.S.W. prior to September 1985.

The total membership of N.A.S.W. at the time of sampling was 94,939. There are 6,014 members in the Illinois Chapter; and 4,000 members in the Chicago area, which represents two-thirds of the total Illinois Chapter membership.

Approximately 10 percent of the <u>total</u> N.A.S.W. membership are identified as racial minorities (i.e., Asian, American Indian/Pacific Islander, Black and Hispanic.) Whereas 9 percent of the <u>Illinois</u> Chapter are identified as minorities and 11 percent of the <u>Chicago</u> area N.A.S.W. members are identified as minorities.

The (disproportionate stratified) sample selected (N=313) in this study consisted of 118 Black and 139 White social workers. In addition, the total population of Hispanic (N=22), American Indian (N=5) and Asian-American (N=29) social workers in the Chicago area were sampled, due to their small size. A large N of Blacks was chosen to ensure adequate cell sizes to facilitate staistical analysis.

As outlined above, a total of 313 names were drawn, using a table of random numbers, from the Chicago area N.A.S.W. membership list. Twelve (12)

questionnaires proved to be undeliverable (i.e., incorrect address, respondent died, etc.); therefore, the sample selected was reduced to 301 subjects.

Responses were received from 131 practitioners, a yield of 44 percent. This response rate is considered normal for a professional population where a mailed questionnaire is utilized (Bailey, 1982). Another factor that may have affected the response rate was the length of the mailed questionnaire, which took approximately 30 minutes to complete.

DATA COLLECTION INSTRUMENT

The instrument used was a questionnaire developed specifically for this study that was comprised of two sections. The first section elicited responses to demographic questions regarding the participants' race or nationality and years of clinical experience etc.

The second part of the questionnaire consisted of sets of questions, requiring the respondent to make judgments about different (ethnic/racial/cultural) groups. Two analogues per ethnic group were provided so that the levels of acculturation could be altered in order to present all possible combinations of the two within-subjects I.V.s. (See Appendix B for the actual instrument.)

After each vignette there was a twenty item scale, Cross-Cultural Clinical Judgment Inventory (CJI), designed to elicit judgments that were considered to be reasonably representative of the kinds of clinical decisions practitioners make - implicitly or explicitly - in actual practice. A comprehensive listing of clinical judgments made in the general area of differential assessment and service planning as well as clinical issues/decisions that confront practitioners in intercultural counseling situations were included in the C.J.I. The twenty (20) items in the C.J.I. were carefully chosen to include relevant items that have been selected in other clinical judgment studies, as well as items considered to be important issues in the cross-cultural counseling context. The instrument was also pretested and reworded to avoid ambiguity and poor phrasing.

The C.J.I. is a 20-item scale that asks the respondent to judge, on a 4-point scale, the degree to which they think that race, ethnicity or cultural issues/factors are important/relevant to the disposition of the particular case vignette. The 4-point scale ranges from not important or relevant (1) to very important (4). A potential range of

scores is from 20 to 80; higher scores indicate greater importance of race, ethnicity or cultural issues/ factors. Scores on each of the twenty (20) items in the C.J.I. scale were summed to achieve one score: clinical judgment.

(Development of the Case Analogues: Conceptual, Theoretical and Empirical Considerations)

An attempt was made to include all possible combinations of the four different (racial/cultural/ ethnic) client groups and the two levels of acculturation.

The four (ethnic/cultural/racial) groups used in the analogues were: Jewish-American, Afro-American, Polish-American, and Puerto Rican. These groups were selecteo, in part, because they would enable representation from client groups considered to be White as well as racial minority. Whereas these client groups were not all inclusive, they are highly representative of client groups serviced by social workers in agencies.

"Marginally" acculturated individuals were not chosen because of the likelihood that these individuals would not speak English (or standard English) well enough to engage in a verbal counseling process. Although bilingualism and language barriers

are always present as clinical issues to be addressed and/or considered in any intercultural counseling situation, the bilingual client presents issues of a slightly different nature from the individual who barely speaks or does not speak standard English. Additional considerations in the omission of the "marginal" level client analogue was the likelihood that recent immigration and assimilation issues would more likely play a larger role, and unduly complicate the vignette scenarios. Thus, "high" acculturated and "moderately" acculturated families were chosen for the analogues.

The term "acculturation" is conceptually defined in this study as the acquisition of the culture of the dominant group, to the extent that the individual achieves competence in that cultural context. This process is generally viewed as a healthy adaptation to the larger socio-cultural environment, and is seen as being ego syntonic to the individual, as one does not lose one's own ethnic identity or pride in the process.

In addition, the level of acculturation is operationally defined in this study as the extent to which individuals represent the "cultural prototype" of their own subculture and the degree to which they

are embedded to their own subcultural values, traditions, etc.; or to the degree to which they are acculturated to the dominant (American) culture.

Specific labeling of the client's social class as well as obvious traditional social class indicators (i.e., income, level of education and occupation) were avoided in the case vignettes. The clinical judgment literature has clearly documented that the variable of social class brings with it biases and clinical preconceptions (Briar, 1960, Fischer, 1970 and Franklin, 1985). This is not to imply that individual respondents will not infer social class given other indicators; however, no specific reference to social class was made in the analogues.

Certain issues were purposely avoided in the construction of the case vignettes, that is, issues wherein culture and ethnicity are inherently the central focus of the concern. This exclusion was seen as necessary so as not to unduly, and further, complicate the clinical decisions to be made by the respondents. It was also felt that explicit cultural concerns presented in the analogues would become too obvious of an indicator of the respective degree of client acculturation. The purpose of this study was to analyze whether practitioners would be sensitive to

the client's level of acculturation, given general clinical concerns, and not to analyze how well practitioners handle specific cultural conflict situations. Therefore, case analogues purposely excluded: situations where clients struggled with their minority or ethnic identity; explicit concerns regarding racism, ethnocentrism and prejudice; and conflicts between the dominant culture and their own sub-culture.

Ethnocultural factors are more powerfully played out in family relations than in any other arena, and one's ethnicity is deeply tied to the family, through which it is transmitted (McGoldrick and Pearce, 1982). Therefore, it seemed prudent that all case analogues be centered around families. Thus, each case vignette was systematically developed to involve a family presenting one of their children's behavior as a concern.

Each family included a vignette, featuring behaviors and/or characteristics exhibiting the most usual, normative and statistically average, characteristics of that particular subculture - as reported in the ethnographic and sociological literature. These average/normal/modal (statistically frequent) behaviors feature the four moderate or low

acculturated vignettes for the four ethnic client groups.

In contrast, four other vignettes featured families that exhibited statistically less frequent (non-modal) but nonetheless "culturally-normal" patterned behaviors and characteristics for each of the four ethnic client groups. These vignettes were seen as representative of highly acculturated families.

The result of these procedures are eight case analogues featuring: a high acculturated and low acculturated- Jewish-American, Polish-American, Afro-American and Puerto Rican family vignette.

Six dimensions identified as universals on which cultures vary, were selectively and uniformly utilized to illuminate the behaviors/characteristics/features of the two with-in subjects factors, race/ethnic status and acculturation of the client. The parameters of culture, as they vary among the groups represented in the eight analogues) was selected as a method that most systematically operationalized the concepts of race/ethnic status and level of acculturation for each client/family.

The specific parameters of culture selected in the construction of the eight vignettes were (see

Appendix C for a complete outline of The Parameters of Culture):

Family Form: structure of the family, functions of the family and roles therein, residence patterns, conjugal roles;

Interactional Style: the habitual patterns of interactional behavior;

Psychosexual Development: child rearing practices, puberty;

Concepts of Illness: folk concepts of disease, folk healing practices, patterns of expression of complaints;

Coping Patterns: social network, recreational forms, traditional "helpers", ideals of management of illness;

Manifestation of Illness: epidemiology cross-culturally, differential rates and kinds of illness in different cultures and sub-cultures.

SUMMARY OF DATA COLLECTION PROCEDURES

Each participant received a cover letter and mailed questionnaire, comprised of two sections. The first section elicited demographic data on the participant and the second section consisted of sets of questions following eight case analogues - presented in a standardized order.

The participants were asked to complete all sections and analogues, in the order presented, and to return the questionnaire in the pre-addressed stamped enveloped provided. An abstract of the results of the study was offered as an incentive for completion of the instrument. Two follow-ups were executed to increase the response rate (see Appendix D-H for cover letters.)

DATA ANALYSIS

The primary statistical procedure used in this study was the univariate (mixed-model) ANOVA for repeated measures (mixed-model) designs. If the assumptions are met, the mixed-model ANOVA is the most powerful method of analysis for repeated measures designs.

This study avoids the distributional assumptions of the mixed-model ANOVA by using (univariate) planned a priori comparisons of specific subsets of (independent) variables. The a priori testing of specific univariate hypotheses versus omnibus hypotheses testing is, in actuality, the most desirable method of analysis for this study; given the intent to test specific hypotheses that seek to reject or confirm whether there are significant differences in means within (and between) each of the four pairs

of cultural/racial/ethnic analogues. The literature also recommends the avoidance of omnibus significance tests in favor of specific planned comparisons, whenever hypotheses more specific than omnibus null hypotheses may be formulated a priori (Hertzog and Rovine, 1985).

In summary, a repeated-measures ANOVA with two between-subjects factors and two within-subjects factors was performed to analyze the effect of each main effect (i.e., client's level of acculturation, client's race/ethnic status, practitioner's race and practitioner's years of clinical experience) and their interactions. In addition, post-ANOVA pair-wise T-Tests was performed on each of the univariate contrasts, to analyze differences (in clinical judgments) within and across racial/ethnic/cultural client groups (i.e., Jewish-high acculturated analogue contrasted with Jewish-low acculturated analogue or Puerto Rican-high and low acculturated analogues contrasted with Polish-high and low acculturated analogues or Black-low culturated analogue contrasted with Jewish-low acculturated analogue.)

The hypothesis that social workers are able to appropriately differentiate the level of acculturation within a specific client group will be evidenced by a

significant difference in means (i.e., post-ANOVA pair-wise T-Tests), within each pair of racial/ethnic group analogue, indicating that they would consider cultural issues/ factors to be more important for low acculturated vignettes (high scores) and conversely that cultural issues/factors to be of lesser import for high acculturated vignettes (low scores). This analysis was expected to answer the question whether social workers tend to overassess or underassess cultural phenomenon within specific groups, by comparing whether high scores appropriately accompany low acculturated vignettes and vice versa.

An additional hypothesis that can be answered by a priori specific comparisons is: the effect of the practitioner's race and/or years of clinical experience on clinical judgments will result in differences in means within (and/or between) pairs of cultural/racial/ ethnic client analogues among these independent-group factors. This would indicate that these variables enhance, or have no effect upon, diagnostic acuity in clinical judgments.

Finally, the a priori approach to hypothesis testing will facilitate an answer to the hypothesis: that given the same level of client acculturation, in the case vignettes, social workers will not show

significant differences in means between the various cultural/racial/ethnic client analogues (i.e., comparison of low or high acculturated cases.) This would indicate that they would consider cultural issues/factors to be equally important or equally not important, depending on which levels of acculturation are compared, across (cultural/racial/ethnic) client groups and thus are not stereotypically responding to the client's race/ethnic status. This would also indicate that they are taking into account, in their clinical decisions, the importance of the client's level of acculturation. However, significant differences in means between various client groups, given the same levels of client acculturation, would indicate that the level of acculturation was ignored and stereotypical clinical decisions, based on client's race/ethnic status, were rendered.

Chapter Four

Results of Data Analysis

SAMPLE

The sample size in this study was N = 301. Questionnaires were received from 131 practitioners, a response rate of 44 percent. Of those questionnaires returned, fifty-five were from Whites, forty-eight were from Blacks, and the remaining twenty-eight belonged to other racial minority groups.

The attempt to compare the clinical judgments of equivalent numbers of Black and White social workers was not undermined by the pattern of response rate; in that 41 percent of the Black and 41 percent of the White social workers returned completed questionnaires. Fifty-four percent of the social workers in the "other racial minority group" category also returned completed questionnaires. Thus, the pattern of the response rate will not need to be considered in the data analysis.

With reference to the other between-subjects factor, years of clinical experience, forty-five had 0-3 years of experience, twenty-four had 4-6 years of experience, and sixty-two had over 7 years of experience. Thus, the respondents represent a fairly heterogeneous sample with respect to years of clinical experience; and the results of the data analysis can be viewed as being reflective of a heterogeneous population.

Of the 131 respondents: N = 115 had M.S.W. degrees, N = 14 were M.S.W. graduate students and N = 2 were B.S.W. students. Therefore, the data results largely reflect the responses of M.S.W.'s and limited generalizations from this study should be made to B.S.W. level social workers.

With the exception of the sex of the practitioner, 81 percent were female, related demographic information revealed a fairly even distribution and heterogeneous population with respect to practitioner's age and annual personal income.

This sample was somewhat more heavily influenced by practitioners who "state" that their theoretical orientation is psychodynamic (37 percent); however, other approaches are also well represented (eclectic 20 percent, family/systems 13 percent, cognitive 8

percent, and behavioral 18 percent.) Thus, data results can be viewed as being reflective of a fairly heterogeneous sample of social workers.

Finally, respondents were asked to indicate "with which cultural/racial/ethnic client group did they have the most clinical experience." The majority of the respondents (73 percent) indicated that they had the most clinical experience with Black clients. Therefore, it would be logical to speculate that responses to the Black family vignettes would also be reflective of a sample of social workers whose clinical experience rests largely in work with Black clients. That is, one would predict that, in this sample of social workers, they would be able to differentiate the level of acculturation (in the Black family analogues) in their clinical judgments.

Listed below is a table that summarizes the demography of the sample of social workers, represented in this study. Whereas several practitioner characteristics were collected, only two variables (race and years of clinical experience) were used in the data analysis.

Table 2.

Demography of Sample (Practitioner Characteristics)

Race	Black	White	Other		
	48	55	28		
YRS of	0-3	4-6	Over 7		
Clin Exp	45	24	62		
Degree	MSW	Grad.Student	BSW Stud.		
earned	115	14	2		
Sex	Male	Female			
	25	106			
Theor	Psych	Fam/system	Cognitive	Behav	other
orien	48	17	10	23	33
Exper	Black	White	Hispanic	other	
w/clnt	72	36	15	8	
cultural					
grp					

n=131

PRELIMINARY DATA SCREENING

Before the main statistical procedure (repeated-measures ANOVA) was performed, the data was reviewed by studying differences in means. Whereby this preliminary screening of data would not indicate if differences found were significant; however, the differences in means may yield some tentative indications of patterns of differences to be revealed by the main analysis.

Arithmetic differences in means in clinical judgments between the four "high level of acculturation" vignettes (see Table 3) potentially indicate that this sample of social workers are sensitive to and are able to differentiate the level of acculturation in the eight analogues. Furthermore, mean scores would also potentially indicate that they are also able to "appropriately" address the client's level of acculturation - as indicated by corresponding high scores for the "low level of acculturation" vignettes. This would indicate that they perceived cultural issues/factors to be more important for low acculturated clients and vice versa e.g., cultural issues are not as important/relevant for highly acculturated clients.

Table 3.

Means of Clinical Judgments (By Client's Level of Acculturation)

Analogues (level of acculturation)	Mean Scores
High Level of Acculturation	42.41
Low Level of Acculturation	48.92

When studying the differences in means in clinical judgments between the four sets of ethnic/racial group analogues, one also notes distinct patterns. First, the two White ethnic client groups (i.e., Jewish and Polish) have lower mean scores than the two racial minority client groups (i.e., Black and Puerto Rican) (see Table 4.) This potentially indicates that social workers perceived cultural issues/factors to be of lesser importance in practice with the White ethnic client. Secondly, the mean scores of the two White ethnic groups are within two points of one another, as are the mean scores of the two racial minority groups. Potentially indicating that social workers tended to view the two White ethnic groups similarly, and the two racial minority groups similarly - with reference to the importance of cultural issues in the analogues.

Table 4.

Means of Clinical Judgments (By Client's Race/Ethnic Status)

Analogues (race/ethnic status)	Mean Scores
Black	46.51
Puerto Rican	48.89
Jewish	44.53
Polish	42.74

When viewing a slightly different breakdown of the mean scores of clinical judgments (see Table 5) the pattern of differences between means within each of the four ethnic/racial groups also revealed that there is a larger arithmetic difference in means between the high and low acculturated vignettes of the White ethnic analogues (i.e., Jewish and Polish), than there is within the analogues of the two racial minority groups (i.e., Black and Puerto Rican.) This pattern of differences between means would potentially indicate that this sample of social workers were better able to distinguish between the levels of acculturation with the White ethnic analogues than they were with the racial minority analogues.

Table 5.

Means of Clinical Judgments (By Within Subjects/Client Variables)

Client's Level of Accul.	(Client's Race)			
	Jewish	Polish	Black	Puerto Rican
High	39.13	38.41	45.46	46.66
Low	49.93	47.07	47.56	51.11

It is also interesting to note among the mean scores of the high acculturated client vignettes (see Table 5) that there is more similarity in score means between the two White ethnic groups and between the two racial minority groups, than there is when a White ethnic group score means is contrasted with a racial minority group score means. In addition, both of the racial minority client groups have much higher score means than the two White ethnic group score means, for high acculturated cases, (see Table 5.) This potentially indicates that even with the highly acculturated client, this sample of social workers'

perceived cultural issues to be of <u>even</u> more importance with the racial minority client.

The arithmetic difference in mean scores of clinical judgment between the race of the practitioner is not very large (see Table 6.) One would tentatively state that Black, White and other (racial minority) social workers tended to judge the analogues similarly. Thus the lack of arithmetic differences in mean scores would potentially indicate that the race of the practitioner did not reveal marked differences in clinical judgments.

Table 6.

Means of Clinical Judgments (By Between Subjects/ Practitioner Variables)

Practitioner's Years of Clin. Experience	(Practitioner's Race) Black	White	Other	Overall Means (yrs. clin.)
0-3	55.68 n = 8	44.68 n = 28	49.86 n = 9	47.67 n = 45
4-6	39.94 n = 7	38.09 n = 12	38.67 n = 5	38.75 n = 24
Over 7	46.89 n = 33	46.88 n = 15	47.09 n = 12	46.93 n = 60
Overall Means (Prac. Race)	47.34 n = 48	43.84 n = 55	46.43 n = 26	n = 129

The arithmetic difference in mean scores of clinical judgment between the years of clinical experience revealed that the least experienced practitioner group and the most experienced practitoner group had similar mean scores (i.e., 47.67 and 46.93) (see Table 6.) In addition, these two groups had higher mean scores than the 4-6 year practitioner group. Thus, indicating that the 0-3 and Over 7 year practitioners' groups (overall) perceived cultural issues to be more important in the analogues than did the 4-6 year practitioner group. (You will also note that the Black practitioners group had the most clininal experience.)

Finally, when analyzing the cell means of Table 6, the 0-3 year practitioner group had the largest arithmetic differences in mean scores across the three categories of practitioner race (i.e., 55.68, 44.68, and 49.86.) Conversely, the 4-6 year and the Over 7 years practitioners' groups had similar mean scores, across all three practitioner's race categories. Thus it appears that score means become more similar, and possibly clincial judgments become more similar, with increasing years of clinical experience, for all the practitioner race categories.

MAIN EFFECTS AND INTERACTIONS

To investigate the effects of each (main and interactive) effect, a repeated-measures ANOVA with two between-subjects factors and two within-subjects factors was performed. The listwise deletion option for missing data was used throughout the analysis in this study for simplicity. Since there was very little missing data (N = 2), the type of missing data option used would not make much difference (if any) in the results. Finally, the alpha level to be used in this study to determine statistical significance is $p < .05$.

Univariate F tests on the two within-subjects factors (client's race/ethnic status and client's level of acculturation) were statistically significant ($p<.05$). However, only one of the two between-subjects factors (practitioner's years of clinical experience) was statistically significant ($p<.05$). The variable of practitioner's race was not statistically significant ($p>.05$). Results of these analyses are summarized in Table 7.

Table 7.

Main Effects of Client's Ethnicity and Level of Acculturation, and the Practitioner's Race and Years of Clinical Experience on Clinical Judgments

Effect	df	SS	F-value	PR>F
Client Ethnicity	3	3031.36	18.25	0.0001
Client Accul.	1	7852.80	141.80	0.0001
Prac. Race	2	2770.86	1.32	0.2700
Yrs. Clinical	2	13245.53	6.33	0.0024

N = 129

Of the nine interactive effects tested, only three achieved statistical significance ($p<.05$). There was a highly significant interactive effect between client's ethnicity and client's level of acculturation ($p=.0001$). There was also an interactive effect between client's level of acculturation and practitioner's race ($p<.05$). Finally, a three-way interactive effect between the client's ethnicity, the practitioner's years of clinical experience and the practitioner's race was statistically significant ($p<.05$). Results of these analyses are summarized in Table 8.

Table 8.
Interactive Effects of Client's Ethnicity and Level of Acculturation, and the Practitioner's Race and Years of Clinical Experience on Clinical Judgments

Effect	df	SS	F-value	PR>F
ClntEthn*Accul	3	1937.66	11.66	0.0001
ClntEthn*PracRace	6	428.08	1.29	0.2599
ClntEthn*YrsClin	6	192.04	0.58	0.7481
Accul*PracRace	2	427.35	3.86	0.0215
Accul*YrsClin	2	156.42	1.41	0.2441
PracRace*YrsClin	4	4001.11	0.96	0.4346
ClntEthn*YrsClin*PracRace	12	1672.81	2.52	0.0029
Accul*YrsClin*PracRace	4	460.11	2.08	0.0819
ClntEth*YrsC*PracR*Acul	24	1181.61	0.89	0.6183

N = 129

INTERPRETATION OF RESULTS

Practitioner's race did not reach statistical significance ($p>.05$). This is a particularly important finding in light of the generally accepted perceived notion that in clinical decisions involving cultural matters, personal experiences, vis a vis ethnic background, will enhance diagnostic and overall clinical acuity. However, this study does not provide direct evidence to definitively either support or refute this notion, because the research design was not specifically set up to test possible effectiveness indicators, only to analyze patterns of differences in mean scores. This study does, however, provide important information to warrant serious questioning of the actual effect that practitioner's race has on

clinical judgments, given that there was not a significant difference in mean scores. It is important to note that the size of the effect for practitioner's race may have been too small to be detected by this small sample size.

The practitioner's years of clinical experience was statistically significant ($p<.05$). This indicates acceptance of the hypothesis that this variable does have an effect on clinical judgments. This is a particularly interesting result when contrasted with the finding that the practitioner's race was not statistically significant ($p>.05$). This study indicates that the _professional_ characteristic of the practitioner (i.e., years of clinical experience) is more likely to exert an influence on clinical decisions as opposed to _personal_ characteristics (i.e., race) of the practitioner.

However, in order to assess whether increasing years of clinical experience has an effect on clinical judgment, we must take a look at the specific contrasts when this variable is partitioned. (To be discussed momentarily.)

Years of clinical experience, however, did not have a statistically significant _interactive_ effect ($p>.05$) when combined with either client variable

(i.e., level of acculturation or ethnicity.) Lack of a statistically significant interactive effect, unfortunately precludes a valid analysis, of specific contrasts, of the effect of years of clinical experience with respect to specific racial/ ethnic/cultural groups. Any interpretations rendered on the interactive effects with specific contrasts (discussed in the next section) would be suspect, given a non-significant interactive main effect.

The variable of client's race/ethnic status was statistically significant ($p<.05$). This would indicate acceptance of the hypothesis that social worker's clinical judgments are influenced by the race/ethnic status of the client. However, specific questions as to how the client's race/ethnic status influences judgment (i.e., overassessment, underassessment or stereotypical assessments) and how judgment patterns vary across specific racial/ethnic/cultural groups can only be answered by analyzing specific contrasts (to be discussed in the next section.)

The most striking and powerful effect on clinical judgment, in this study is the effect of the client's level of acculturation. The F had a value of 141.80 that was statistically significant ($p<.05$). This

finding is consistent with the hypothesis that (overall) social workers' clinical judgments will vary according to the client's level of acculturation.

The finding that the client's level of acculturation was the strongest predictor of clinical judgment, as evidenced by its F value, indicates that social workers potentially pay more attention to this variable than, in comparison to the client's race/ethnic status. However, when specific contrasts (between race/ethnic/cultural client groups) are analyzed, this interpretation does not hold. (To be discussed momentarily.)

Nevertheless, it is an important finding that, overall, client variables exert a stronger effect than practitioner variables on social workers' clinical judgment. This is a positive finding; in that clinical decisions should be a function of the client situation, rather than a function of the social worker's characteristics.

Both client variables (level of acculturation and ethnicity) achieved statistical significance ($p<.05$). In contrast, the interactive effect between the two practitioner variables (race and years of clinical

experience) did not reach a statistically significant level ($p>.05$). This would potentially indicate that social workers' clinical decisions could be more of a function of the single and/or interactive effect of client variables as opposed to practitioner characteristics. Thus additional evidence to potentially support the notion that social workers' clinical decisions are more likely to vary with reference to client variables, as opposed to practitioner characteristics. However, it is important to note that tests of interactions generally are less powerful than tests of main effects. Thus, this finding may be attributable to differential statistical power (Orme and Combs-Orme, 1986).

The implication of the findings of the interactive effects will become particularly evident when the results of the specific contrasts are discussed. That is, lack of a statistically significant main effect of practitioner's race ($p>.05$) as well as a statistically non-significant interactive effect between practitioner's race and client ethnicity ($p>.05$) precludes a valid analysis of whether statistical significance levels remain constant, given practitioner's race. Similarly, lack of a statistically significant ($p>.05$) interactive

effect between years of clinical experience and client ethnicity, also precludes a reliable analysis as to whether significance levels remain constant, given years of clinical experience. Again it is acknowledged that any interpretation of interactive effects with specific contrasts would be suspect, given a statistically non-significant interactive main effect.

Study results indicate that client's race/ethnic status interacts with the practitioner's race or years of clinical experience. However, when both practitioner variables are combined, for a three- way interactive effect with the client's ethnicity, there is a statistically significant effect ($p<.05$) on clinical judgment. These results are difficult to interpret - as one can only conclude that the singular effect of each practitioner variable is not sufficient to constitute a statistically significant interaction.

Similarly, the client's level of acculturation did not have a statistically significant ($p>.05$) interaction with the practitioner's years of clinical experience; nor was the three-way interaction with both practitioner variables statistically significant ($p>.05$). However, there was a statistically significant interaction between the client's level of

acculturation and the practitioner's race ($p<.05$). Although the results are somewhat inconclusive (and difficult to interpret), this finding is possibly indicative that whereas the practitioner does not make differential judgments with respect to the client's level of acculturation and his/her years of clinical experience; rather, the clinician does make differential judgments as indicated by the (differences in means) with respect to client's level of acculturation when the practitioner's race is taken into account. However, again it is cautioned that these interpretations are very inconclusive given the mixed pattern of results presented here.

SPECIFIC CONTRASTS

The previous results of the univariate F tests on main effects and their interactions leave many questions unanswered. Although some significant results were achieved, and some global interpretations can be made, it becomes obvious that one can not answer some of the central theoretical questions of interest without specific (univariate) contrasts. In addition, some of the patterns of statistical significance achieved, analyzing main effects do not hold for particular racial client groups. These

findings are important as we seek to understand clinical judgment patterns with reference to specific racial/ethnic/cultural client groups. Therefore, post-ANOVA (repeated measures) pair-wise T-Tests were performed on each of the univariate contrasts, to analyze differences, in clinical judgments, within and across racial/ethnic/cultural client groups. The analysis was done using the least square means scores to adjust for unequal sample sizes in the between-subjects factors.

The results of the post-ANOVA t-tests on the effect of years of clinical experience (i.e., 0-3 years, 4-6 years and over 7 years) revealed that there are statistically significant differences ($p<.05$) in clinical judgment between the practitioners with 0-3 years of experience and the practitioners with 4-6 years of experience. There was also a statistically significant difference found ($p<.05$) between the practitioners group with 4-6 years of experience and practitioners with over 7 years of experience. However, no statistically significant difference was found ($p>.05$) between the 0-3 years and the over 7 years practitioner group.

Table 9.

Least Square Means Scores of Years of Clinical Experience

Effect	LS Mean
0-3 years	50.078
4-6 years	38.905
over 7 years	46.958

N = 129

The results of these analyses are mixed, revealing a non-linear effect and a curvelinear relationship. Whereas, there appears to be some indication that increasing years of clinical experience influences clinical judgment; however, the full analysis does not sustain this conclusion. The least square means scores (and post-ANOVA T-Tests results) of years of clinical experience (see Table 9) do not reveal a consistent pattern that lends itself to logical interpretation. Thus these results are not as predicted.

One of the most important questions to be answered by this study is whether social workers are able to distinguish between levels of acculturation within racial/ethnic client groups in their clinical judgments. [As evidenced by a significant difference in mean scores (in the case vignettes) in the

repeated-measures ANOVA.] The cross-cultural counseling field determines the ability to distinguish between levels of acculturation to be at the heart of a basic ability to provide culturally appropriate and effective services to clients.

Means scores of clinical judgments of "low acculturated" and "high acculturated" case analogues (see Tables 1, 3 and 4) indicate that social workers generally perceived that cultural/racial/ethnic factors and issues were more important in the corresponding low acculturated case vignettes, as shown by corresponding higher means scores. Similarly, lower mean scores on the corresponding high acculturated case analogues also indicate that social workers generally perceived cultural/racial/ethnic factors and issues to be of lesser importance (see Tables 1, 3 and 4) for more highly acculturated client groups. These mean scores establish that differences in clinical judgment scores "appropriately" correspond with either high or low acculturated case vignettes and reflect perceived importance of the client's level of acculturation. This finding also gives support to the validity of the CJI measurement tool.

Given that it has been established that mean scores suggest that social workers do perceive

differences, in levels of acculturation, in these analogues with "appropriate" corresponding scoring patterns - the results of the post-ANOVA T-Tests will reveal if these mean differences are significant.

As suggested by the arithmetic difference(s) in overall mean scores, the results of the post-ANOVA repeated-measures T-Tests show that statistical significance levels ($p<.05$) are reached <u>within</u> the two case analogues (high and low acculturated) of the Jewish, Polish and Puerto Rican family case vignettes (see Table 10). There was not a statistically significant difference in means within the two Black family case analogues ($p>.05$). It is also interesting to note that significance levels were very high ($p=.0001$) for the Jewish and Polish client groups; and a much lower significance level ($p=0.387$) was reached within the Puerto Rican case analogues.

Table 10.
Univariate Contrasts Effects Within Race/Ethnic/Cultural Client Groups on Clinical Judgments

Effect	PROB>T
(Black) = BHA & BLA	0.1409
(Puerto Rican) = PRHA & PRLA	0.0387
(Jewish) = JHA & JLA	0.0001
(Polish) = POLHA & POLLA	0.0001

N = 129

These results tend to indicate that social workers are able to "appropriately" distinguish between levels of acculturation within the Jewish, Polish, and Puerto Rican analogues, but not within the Black analogues. In addition, these contrasts between the significance levels suggests that social workers' ability to distinguish between levels of acculturation is much more evident in the Jewish and Polish family case analogues than within the Puerto Rican case analogues.

These results suggest that social workers' cross-cultural effectivness (i.e., ability to distinguish between levels of acculturation) is <u>not uniform across all racial/ethnic/cultural client groups</u>. Furthermore, these results suggest that the client's race/ethnic status may be a more influential concept, than the client's level of acculturation, in deciding upon the relative importance of cultural factors with racial minority groups (e.g., Black and Puerto Rican) than it is with White ethnic groups (e.g., Jewish and Polish.)

These findings would also tend to indicate that the race (of the client) appears to be used as a central and guiding construct in clinical practice with racial minority groups. Whereas the broader

concept(s) of culture i.e., attention to specific subcultural information, such as level of acculturation, appears to be used as a guiding construct in clinical judgments within White ethnic client groups.

These results also suggest that there may be a problem of stereotyping of the Black client; and an inability to see Blacks as a heterogeneous group that require <u>differential</u> diagnostic and interventive decision making.

These analogue research results are consistent with actual empirical clinical studies that have documented ineffectiveness, massive stereotyping, mechanical processing and the provision of less preferential services to Black clients (Sue, 1977; Garfield, 1986).

When specific contrasts between client groups were made (See Table 11), results show that there were statistically significant ($p<.05$) differences in means found in the contrasts between racial minority versus White ethnic client groups (i.e., Black versus Polish; Puerto Rican versus Jewish, etc.), with the exception of the Black/ Jewish contrast ($p>.05$). However, contrasts between the two racial minority groups (Black/Puerto Rican) <u>and</u> the two White ethnic groups

(Jewish/Polish) revealed that there was not a statistically significant difference in means found ($p>.05$).

Table 11.

Univariate Contrasts Effects Between Race/Ethnic/ Cultural Client Groups on Clinical Judgments

Effect	PROB>T
(Black: Hi & Low) BHLA * PRHLA (Puerto Rican: Hi & Low)	0.1044
(Jewish: Hi & Low) JHLA * POLHLA (Polish: Hi & Low)	0.2189
(Black) BHLA * JHLA (Jewish)	0.2729
(Black) BHLA * POLHLA (Polish)	0.0202
(Puerto Rican) PRHLA * JHLA (Jewish)	0.0066
(Puerto Rican) PRHLA * POLHLA (Polish)	0.0001

N = 129

Theoretically the clinical judgment score means, of the case analogues, should be approximately similar when contrasted with case analogues featuring similar levels of client acculturation. That is, perceived importance of cultural factors as measured by the C.J.I. scale should be approximately equivalent. Thus significant differences in mean scores would indicate that perceived differences, of the importance of cultural factors/issues, may be more of a function of racial assumptions than of actual differences between vignettes.

These findings would potentially indicate that social workers tend to perceive racial minority client groups (i.e., Black contrasted with Puerto Rican) and White ethnic client groups (i.e., Jewish contasted with Polish) as being more similar to each other, with reference to the perceived importance of cultural factors in clinical judgments. However, when racial minority and White ethnic client groups are contrasted (i.e., Black with Polish; Puerto Rican with Jewish), there is a pattern of significant differences ($p<.05$), reflecting a difference in the perception of the relative importance of cultural factors in the vignettes.

Lack of statistically significant differences ($p>.05$) found in the contrasts between the Black/ Puerto Rican and Jewish/ Polish client groups combined with the finding of statistically significant differences ($p<.05$) between Black/Polish, Puerto Rican/Polish and Puerto Rican/Jewish client groups tend to suggest that the race/ethnic status of the client plays a more influential role in deciding upon the relative importance of cultural factors/ issues, than does the variable of client acculturation, even when acculturation levels are equivalent.

Similar clinical judgment patterns, of differences and non-differences, are revealed when contrasts are made between racial minority and White ethnic family (high acculturated) case analogues (see Table 12).

Statistically significant differences ($p<.05$) in mean scores are consistently found when high acculturated racial minority case vignettes are contrasted with (high acculturated) White ethnic vignettes.

Table 12.

Univariate Contrasts Effects of High Levels of Acculturation Between Race/Ethnic/Cultural Client Groups on Clinical Judgments

Effect	PROB>T
(Black) BHA * PRHA (Puerto Rican)	0.3949
(Jewish) JHA * POLHA (Polish)	0.9183
(Black) BHA * JHA (Jewish)	0.0045
(Black) BHA * POLHA (Polish)	0.0033
(Puerto Rican) PRHA * JHA (Jewish)	0.0002
(Puerto Rican) PRHA * POLHA (Polish)	0.0002

N = 129

However, statistically significant differences are not found ($p>.05$) when the two high acculturated racial minority analogues (Black/Puerto Rican) are contrasted, as well as when the two high acculturated White ethnic analogues (Jewish/Polish) are contrasted.

These findings would tend to indicate that, given similar high levels of acculturation, social workers tend to perceive more differences between racial minority and White ethnic client groups than they do when the two racial minority groups are contrasted to each other, as well as when the two White ethnic groups are contrasted.

Again these results suggest that social workers may make stereotypical assumptions that all racial minority clients will require differential, special culturally tailored, services (as evidenced in significant difference in means) even when similar high levels of acculturation does not warrant such differentiation.

However, more encouraging results are found when a similar analysis is performed contrasting low levels of acculturation (see table 13). That is, there were no statistically significant differences ($p>.05$) in means found in any of the contrasts involving low acculturated case analogues.

Table 13.

Univariate Contrasts Effects of Low Levels of Acculturation Between Race/Ethnic/Cultural Client Groups on Clinical Judgments

Effect	PROB>T
(Black) BLA * PRLA (Puerto Rican)	0.1480
(Jewish) JLA * POLLA (Polish)	0.1019
(Black) BLA * JLA (Jewish)	0.1959
(Black) BLA * POLLA (Polish)	0.7316
(Puerto Rican) PRLA * JLA (Jewish)	0.8781
(Puerto Rican) PRLA * POLLA (Polish)	0.0736

N = 129

The combined results of these two analytical procedures suggest that social workers are more likely to perceive differences between racial minority and White ethnic client groups when high acculturated case analogues are contrasted, than when low acculturated case analogues are contrasted. This would tend to suggest that social workers may inappropriately perceive differences between high acculturated racial/ethnic client groups. That is, there may be a tendency to overassess high acculturated racial minority clients; which also may be indicative of an inability to perceive similarities between racial minority and White ethnic clients when both groups are highly acculturated.

SUMMARY OF RESULTS

A repeated-measures ANOVA was performed to analyze the effects that the client's race/ethnic status and level of acculturation, and the practitioner's race and years of clinical experience had on social workers clinical judgments. In addition, post-ANOVA pair-wise T-Tests were performed on each of the specific (univariate) contrasts to analyze differences within and across the cultural/racial/ethnic groups.

Results strongly suggest that social workers are sensitive to the client's level of acculturation in their clinical judgments. However, specific comparisons within each of the cultural/racial/ethnic groups reveal that this is not the case across all client groups. That is, there was a marked inability to distinguish between levels of acculturation, in the analogues, within the two Black family case vignettes. Results also showed that social workers were not as able to distinguish between levels of acculturation, in the analogues, within the two Puerto Rican family case vignettes (e.g., lower level of significance), as they were within the two White ethnic family vignettes.

In addition, the analysis revealed that the practitioner's race did not have an overall statistically significant main effect on clinical judgments nor did it have a statistically significant interactive effect with the client's race/ethnic status. However, the fact that the practitioner's race did have a statistically significant interactive effect with the client's level of acculturation renders the results somewhat inconclusive and difficult to interpret; possibly indicating that the practitioner's race _may_ render clinicians more sensitive to acculturation levels.

The practitioner's years of clinical experience did have a statistically significant main effect on clinical judgments; but did not have a statistically significant interactive effect with the client's race/ethnic status or with the client's level of acculturation. In addition, an analysis of the years of clinical experience revealed a non-linear effect (curvelinear relationship) on clinical judgment with increasing years of clinical experience.

The results of this study also indicate that social workers are more likely to perceive differences in the importance of cultural factors between White ethnic as compared to racial minority client groups.

They also are more likely to perceive differences, in the relative importance of cultural factors, between the two sets of White ethnic analogues than they are between the two sets of racial minority client analogues. This patterns tends to be particularly evident and consistent when only the high acculturated case analogues are contrasted between ethnic groups.

Lack of statistically significant results, when the low acculturated case analogues are contrasted, would tend to indicate that social workers are more likely to perceive differences, in the relative importance of cultural factors in the analogues, between racial minority as compared to White ethnic client groups when there is a high level of acculturation.

These findings would tend to suggest that racial minority group clients are more likely to be mechanically processed and overassessed in clinical situations that involve the more highly acculturated minority client.

Overall, this study showed that client variables exerted a stronger influence on clinical judgments than practitioner variables. Finally, this study revealed that professional characteristics of the practitioner tended to exert a stronger influence on

clinical judgments than the personal characteristics of the practitioner.

DISCUSSION OF RESULTS

Empirical answers to important theoretical questions (i.e., what are the differences in clinical judgment patterns across four ethnic client groups with two different levels of acculturation) are only possible if several different case analogues are used in the research design. Particularly if one is interested in comparing and analyzing responses, to all eight analogues, from each respondent in the study. Therefore this study emphasized increased external validity.

Regardless of the necessity of this approach, one risks confounding of the results (i.e., results attributable to multiple factors) with the use of this design. That is, the reader will wonder how much the differences in responses is the result of differences in vignettes? The possible trade-off here between internal and external validity is acknowledged. Given the nature of the research question, this study opted for increased external validity. However, it is not felt that the use of this design largely compromised the results; rather it facilitated answers to important theoretical questions.

The concerns associated with repeated measures designs (i.e., carry over effects) are also acknowledged. The results herein would have been strengthened if counter-balancing were used in the design. This study cannot answer the question: what are the effects of order, of the vignettes, on the dependent variable? However, the patterns of the results, <u>that largely verified the a priori hypotheses,</u> are offered, as the reader questions how much response sets figured into the results.

Racial minority social workers were "over sampled" in order to obtain adequate cell sizes for analysis of between-subjects factors. One must use caution in generalizing the results of this study to the general population of social workers; even though the variable of the practitioner's race was not found to be a statistically significant variable in this study.

Finally, lack of statistically significant findings of the interactive effect between the client's race/ethnic status and years of clinical experience and/or practitioner's race prevented the analysis of how these variables influenced the outcomes of the specific a priori comparisons.

Therefore this study raised, but did not answer some important questions concerning practitioner variables.

Chapter Five

Implications for Future Research, Cross-Cultural Training, Professional Education and Clinical Practice

FUTURE RESEARCH

Studies similar to this one, using other cultural/ racial/ethnic client groups, would answer some important questions as to whether the clinical judgment patterns that emerged in this study are sustained with these additional racial/ethnic groups. It would be important to find out if clinicians' responses remained constant with Asian-American, American Indian, Italian, Irish or new immigrant groups, etc. Important comparisons and contrasts could be evaluated with reference to the clinical judgment patterns witnessed in this study and in subsequent studies involving additional client groups.

In addition, modification of the data collection instrument to include an addendum that allowed the

respondent to specifically choose among assessment and interventive strategies would provide rich information that would allow direct observation and operationalization of the clinical judgment process. For instance, comparisons could be made as to which modality, or theoretical orientation was chosen for particular groups, given different levels of acculturation. This would allow examination as to whether respondents actually followed through with corresponding strategies, given previous numerical indication of the perceived importance of cultural factors in the analogues.

Studies that analyzed affective and cognitive measures could be strengthened with the inclusion of a behavioral measure similar to the one used in this study. The relationship between attitudinal shifts and increase in cultural knowledge, using control groups, could be compared to the responses to the analogues, to examine if improvement in these areas translate to increased "sensitivity" to cultural issues. This would be a useful evaluation instrument for professional education and cultural training groups.

Future research efforts should flow from the outcome of actual clinical studies that measure

various effectiveness indicators, and judgments made, with different ethnic/racial groups. In addition, future research should study aspects of professional behavior, i.e., judgments made or not made about minority clients, in order to develop more clearly the issues that need to be more comprehensively addressed in clinical practice and professional education.

Finally, this study made a significant step toward developing and validating an instrument that measures one aspect of cross-cultural sensitivity, in clinical judgments, to cultural issues across racial/ethnic/ cultural groups. Efforts toward modifying this instrument, to facilitate its use in effectiveness studies, should aim to gather systematic evidence concerning various aspects of its validity.

CLINICAL PRACTICE

The results of this study that indicate that social workers differentially perceive the importance of cultural factors given varying degrees of client acculturation, as shown in significant differences in means scores of analogues, are very encouraging with reference to the implication for culturally appropriate clinical practice. However, the finding that this pattern does not hold for the Black family analogues provides some empirical evidence to question

whether in real practice if Blacks are seen as a homogeneous group, and if ethnocentrism and stereotypical assumptions cloud systematic differential clinical decision making. This finding is particularly surprising, as well as disconcerting, given the dmeographic data on this sample of social workers, where 73 percent indicated that most of their clinical experience was with Black clients.

This study would also imply that highly acculturated racial minority individuals may be more at risk of being overassessed and inappropriately served, with reference to the assumption of the importance of cultural issues.

These observations would indicate that perhaps "cultural savvy", with reference to clinical acuity, does vary across specific ethnic/racial/cultural groups. It would also indicate that we need to develop a method for assessing these clinical skills across groups, so that we can be on guard for the overassessment or underassessment of cultural factors, especially with groups that we feel we are less skilled. This type of measure would help us not only to identify areas that need to be targeted in in-service training programs, but would prevent us

from making erroneous assumptions regarding clinical skills with certain groups.

The findings indicate that the race/ethnic status of the racial minority client exerts more powerful influence in deciding the relative importance of cultural issues than it does with the White ethnic clients, where the level of acculturation seems to exert a more powerful influence. The above would indicate in real practice situations that client variables, race versus level of acculturation, tend to be used differentially as guiding constructs in clinical practice, depending on the specific racial/ ethnic client group involved. That is, depending on whether the client is from a White ethnic or racial minority client group, the practitioner may perceive (assume) either that the level of acculturation is a critical factor or that the race/ethnic status is a critical factor. This study advocates that given the client's race ethnic status - the level of acculturation must be considered in <u>all</u> client groups.

This study showed that differences, of perceived importance of cultural issues/factors, between racial minority and White ethnic client groups are more likely to be inferred when client groups are highly acculturated. In addition, results showed that

practitioners are more likely to perceive differences, in the relative importance of cultural issues, between racial minority and White ethnic client groups, than they are between the two White ethnic client groups (i.e., Polish contrasted with Jewish) or the two racial minority client groups (i.e., Puerto Rican contrasted with Black.) In an actual clinical practice situation, this could possibly result in the overassessment of the more highly acculturated racial minority individual and thus result in inappropriate services. That is, highly acculturated minority individuals may be inappropriately served if given differential type treatment from highly acculturated mainstream Anglo- Americans.

Therefore, this study would suggest that we need to reexamine our own stereotypic assumptions, cross-cultural clinical skills and/or differential emphasis placed on the client variables of race/ethnic status and level of acculturation and make appropriate adjustments.

In general, this study showed that the practitioner's race did not exert a powerful (and consistent) influence on clinical judgment. These results have implications for clinical programs that rely <u>heavily</u> on the "ethnic matching" of client and

counselor. Many of these programs make assumptions that a clinician from a similar ethnic background is inherently more skilled and effective. Whereas, this study does not give strong enough evidence to refute this notion; the results do emphasize that we need to consider how and why do we expect these "ethnically similar" counselors to be more effective, and put these expectations and assumptions to further empirical test.

Finally, this study sheds serious doubt that we have gone full circle in the shift from race to culture (acculturation) as far as the utilization of either concept as a guiding construct in clinical practice. What this study does potentially point up is that there is yet some "unevenness" in our clinical acuity, with respect to various racial groups. This is not a new discovery, as revealed in actual empirical clinical studies. What is new, is that this study may shed light on operationalizing factors i.e., whether the client's degree of acculturation is addressed, that could be contributing to this "clinical unevenness"; and give direction for future lines of inquiry in evaluation research, professional education and the development of practice principles.

PROFESSIONAL EDUCATION AND CROSS CULTURAL TRAINING

The ability to distinguish between levels of acculturation and appropriately address these differences in clinical judgments should be an area of concern in professional education and in-service training. This study points to the possibility that these skills are not necessarily uniform across all racial/ethnic/cultural client groups; and that more attention may need to be given to certain cultural groups.

Sound theoretical and conceptual skills, with reference to cultural "sensitivity", need to be specifically developed and nurtured, rather than the assumed existence of "practice wisdom" gained via personal experiences in the practitioner's ethnic heritage and cultural background.

Furthermore, this study would indicate that professional education and cross-cultural training programs need to direct their efforts to: 1) develop clinical skills across cultures and 2) aid the clinician to reduce,as much as possible, stereotypic notions and ethnocentric attitudes that may hamper cultural sensitivity and clinical effectiveness.

This study attempted to emphasize the importance of understanding and attending to cultural variables

in all clients - regardless of ethnic or racial, majority or minority background. Hence, the author promotes a deemphasis on race in professional education replaced with a renewed emphasis on the broader concept(s) of culture, and specific cultural variables. Furthermore, professional educators should train practitioners how to use the client, as a "cultural road map", to learn about the client's culture, in planning culturally appropriate interventions. This clinical approach would allow the practitioner unlimited access to specific cultural information as well as help to reduce the risk of oversimplification and stereotypification of the client's sub-culture.

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Appendix A

Case Name;

Case Number:

Instructions: "Please use numbers 1 - 4 to indicate your opinion for each item: 4 = very important; 3 = important; 2 = somewhat important; and 1 = not important or relevant."

In the disposition of this case, how prominently does Race, Ethnicity or Culture figure in the ......

Mark below:

1. assessment/diagnosis
2. (overall) service planning
3. expected length of service
4. unit of attention (social system) for interventive focus
5. structural determinants (time, frequency, place) of interventions
6. etiology (origin/cause) of presenting concern
7. use of therapeutic relationship
8. symptom course and manifestation
9. modality of choice (i.e., individual, group, family, marital, etc.)
10. practitioner style (i.e., authoritarian vs. egalitarian, etc.)
11. theoretical orientation of choice (i.e., behavioral, cognitive, psychodynamic, eco-systems, etc.)

12. use of culturally oriented social network
13. specific goals (for client system)
14. overall degree of disturbance (of client system)
15. use of directive active vs. non-directive passive approach
16. need for culturally/ethnically similar clinician
17. need for more "subcultural" cognitive information, re: client
18. need for "culturally tailored" service plan
19. prognosis (outlook for change/ resolution) - with - treatment
20. prognosis (outlook for change/ resolution) - without - treatment
21. other, please specify:

Appendix B

Section A

DEMOGRAPHIC INFORMATION

Please indicate the last four digits of your Social Security Number. This will not be used in any attempt to identify you, only to match questionnaire parts.

Please answer the following items. Circle only the appropriate number.

Age

1. -- Under 25 years
2. -- 25-36 years old
3. -- 37-47 years old
4. -- 48-58 years old
5. -- 59 or over

Race/Nationality

1. -- Asian American
2. -- Afro-American
3. -- Mexican American
4. -- Native American/Indian
5. -- Puerto Rican
6. -- White (please specify)

The Place in Which You Were Reared Was

1. -- Urban
2. -- Rural
3. -- Suburban (near major urban area)

Annual Personal Income

1. -- 5,000 - 9,999
2. -- 10,000 - 14,999
3. -- 15,000 - 19,999
4. -- 20,000 - 24,999
5. -- 25,000 - 29,999
6. -- 30,000 - 39,999
7. -- 40,000 or above

How Many Years Lived in U.S.A.

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7. -- Other (please specify)

Sex

1. -- Male

2. -- Female

1. -- Born here

2. -- All my adult life

3. -- Since childhood

4. -- 1-3 years

5. -- 4-6 years

6. -- 7 or more years

The Neighborhood in Which You Grew Up (for the most part) Was:

1. -- racially/ethnically segregated

2. -- racially/ethnically integrated

3. -- racially segregated

4. -- ethnically segregated

Years of (post-MSW Clinical Experience

1. -- 1-3 years

2. -- 4-6 years

3. -- 7-9 years

4. -- Over 10 years

Years of Clinical Experience Clinical with Diverse Ethnic/Racial/ Cultural Groups

1. -- 1-2 years

2. -- 3-5 years

3. -- 6-7 years

4. -- Over 8 years

What Cultural/Racial/ Ethnic Client Group(s) Have You Had The Most Clinical Experience With (please specify - Top Two):

Clinical Groups

A. # of Years

B. # of years

Socio-Economic Status (SES) of Clients You Have the MOST Clinical Experience

1. -- Lower income

2. -- Middle income

3. -- Upper income

4. -- About even across all SES groups

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Professional Status (Primary)

1. -- Student (undergraduate)
2. -- Student (graduate)
3. -- Clinician/Practitioner/ Therapist
4. -- Supervisor
5. -- Agency Administrator
6. -- College Professor
7. -- Researcher

Religion

1. -- Catholic
2. -- Jewish
3. -- Protestant
4. -- None (However I was reared:
5. -- Other (please specify:

Please Specify the Theoretical Orientation (e.g., Behavioral, Psychodynamic, Cognitive, etc.) That Most Accurately Reflects Your Present Clinical Practice

Section B

Case Analogues and Indicators

The following section is a series of eight case vignettes. Please read each case and fill out the accompanying questionnaire before going on to read the next case. Repeat the process until you have completed the entire case series.

Please be aware, that for the sake of brevity, only so much case information could be included. Therefore, you should give the best possible opinion that you can, given the limited information.

Thank you again for continuing with this instrument.

Mr. and Mrs. Cohen are first generation Jewish-American of eastern European descent. They have been married for twelve years and have three children (ages 7 - 11). When questioned, they state their religion to be conservative Judaism and that they observe the sabbath and keep a kosher home.

Mr. and Mrs. Cohen are concerned about their 11 year old son's declining academic performance. In the past they have been able to resolve most family concerns with the help of their Rabbi, who finally suggested they seek professional counseling.

Mr. and Mrs. Cohen feel that something must be bothering their son that he needs to talk about; however, since he has not confided in them, they feel maybe he would "open up" to a professional counselor.

The Cohen's spend a lot of time with family, mostly with the wife's family (who lives nearby). They state they also read together as a family and share in other activities.

Mr. and Mrs. Parrish are native midwesterners of Afro-American descent (although both their parents grew up in the South.) They have been married for fourteen years and have two children (ages 9 and 11). When questioned, they state their religion to be Episcopalian and that they attend services mostly on major religious holidays.

Mr. and Mrs. Parrish are concerned about their 11 year old son who has appeared depressed. His appetite has decreased and he seems to lack interest in his previous hobbies, and on occasion seems lethargic. Another parent, from the cultural arts center in their younger daughter's African dance class, suggested they migh seek professional advice.

Mr. and Mrs. Parrish are not aware of any changes or situations in the home or in the school that would be causing this reaction.

The Parrish's spend a lot of time in family outings (overnite camping trips, Black theater, movies, etc.)

They describe their family as a democratic process, and they encourage their children to take a role in family decisions, as well as deciding their own punishment for misbehavior.

Mr. and Mrs. Pulaski are second generation Polish-American. They have been married for twelve years and have five children (ages 4 - 11). When questioned, they state their religion to be Roman Catholic and they regularly attend Mass at a nearby church.

Mr. and Mrs. Pulaski are concerned about their ten year old son who has been exhibiting unruly behavior at home and at school. A nun in the child's school has been trying to work with their son; however, she conceded that probably professional counseling is needed.

Mr. and Mrs. Pulaski feel that their son is stubborn and seems to simply refuse to change his behavior.

The Pulaski's spend a lot of time together and often involve the children in the family gatherings at the local Polish American League (social club). The father is clearly the spokesperson for this family and he is hoping that counseling will be of help in changing his son's behavior.

Mr. and Mrs. Delgado were born in New York (although both their parents were born in Puerto Rico and the wife's parents have recently retired and moved back to the island). Both Mr. and Mrs. Delgado had been previously married and each has a child from their previous marriages. They have been married for ten years and now have three children (ages 7, 12 and 14). When questioned, they stated their religion to be Roman Catholic and that they attended mass sporadically.

Mr. and Mrs. Delgado are concerned about their twelve year old son's recent asthma attacks. They have consulted a series of medical experts, who found no medical basis for these attacks. Finally, with encouragement from their son's compadres (godparents), they decided to seek professional counseling.

Mr. and Mrs. Delgado offered that there are no recent stressors in the home that they are aware of, that could be causing these recent asthma attacks.

The Delgado's spend a lot of time together (camping,

movies). They also make frequent trips to Puerto Rico to visit the wife's family. Mrs. Delgado, who seems to be the family spokesperson, also added they make regular trips back to New York to visit the husband's family.

Mr. and Mrs. Wasserman are third generation Jewish-American of eastern European descent. They have been married for fourteen years. They have two children ages 10 and 12, that attend the nearby public school. When questioned, they state their religion to be reform Judaism and that they mostly observe the high holy days.

Mr. and Mrs. Wasserman are concerned about their 12 year old daughter who has been complaining of headaches and backaches (off and on). They have seen several internists and neurologists, but all the tests have proven negative. Finally, their daughter's pediatrician suggested they seek professional counseling.

Mr. and Mrs. Wasserman are not sure of what would be causing these problems, they say "perhaps there are problems at school with peers," but, again they are not really aware of anything disturbing going on in the home or at school.

The Wasserman family spends a lot of time with their work friends and neighbors, and often plan joint family outings with other families, (i.e., playing baseball in the park).

Mr. and Mrs. Jackson are southern born Afro-Americans, who migrated from the south as teenagers. They have been married for fourteen years and have four children (ages 6 - 13). They also "keep" the wife's sister's child who is 5; as the sister died in an automobile accident when her child was only an infant. When questioned, they state their religion to be Baptist (the father is a deacon in the church and the mother is in the choir).

Mr. and Mrs. Jackson are concerned about their 11 year old son's acting-out behavior. They have encouraged their son to talk with an elder in the church; however, it was finally decided that disciplinarian action was not working and that professional counseling was needed.

Mr. and Mrs. Jackson state that their son "just seems to act up, but then other days he behaves just fine."

The Jackson's spend a lot of time together with their immediate and extended family. They describe their family as close-knit.

Mr. and Mrs. Hollis are third generation Polish-American. They have been married for thirteen years and have two children (8 and 10). When questioned, they stated their religion to be Catholic. They attend Mass as often as possible, but not regularly.

Mr. and Mrs. Hollis are concerned about their 10 year old son's occasional truancy from school. The Hollis' do not use physical punishment in the discipline of their children; however they are very clear with their son that he will suffer from withdrawal of privileges for such serious offenses.

Mr. and Mrs. Hollis are puzzled as to their son's behavior and are not aware of any stressors at home or at school that would be causing this behavior. The school guidance counselor recommended professional counseling after their son's third truancy.

The Hollis' spend a lot of time together (barbequeing, movies, and theater). Mr. and Mrs. Hollis take turns

planning the family's weekend activities and on special occasions (holidays) will include the grandparents.

Mr. and Mrs. Rodriguez are native born Puerto Ricans who migrated to the mainland with their parents as young children. They have been married for fifteen years and have four children (ages 6 - 14). When questioned, they stated their religion to be Roman Catholic and that they mostly attend Mass on major religious holidays.

Mr. and Mrs. Rodriguez are concerned about their eleven year old daughter's nonepileptic seizures (a seizure considered psychogenic in origin). They have exhausted their personal social network of consulting with family and friends. They have even consulted a Spanish healer (espiritismo), who eventually recommended that they take their daughter to a medical clinic. After exhaustive testing, the physician's at the clinic suggested they seek professional counseling.

Mr. and Mrs. Rodriguez feel that "there is something inside their daughter that needs to get out."

The Rodriguez's spend a lot of time with their extensive extended families in frequent family gatherings. The father, who clearly seems in charge, proudly boasts that his family is close-knit.

Appendix C

The Parameters of Culture

(Outline of Universals and Variables of Culture Simplified and Selected for Relevance to Delivery Systems and Clinical Practices in the United States)

COMMUNITY FORM	RELEVANCE
Territoriality (spacing, proxemics).	Physical structures of services and spacing of personnel
Use of Space. (Land use and patterns of movement.)	Location of services, accessibility
Social Structure The structure order. Formal hierarchical sets of statuses and roles in institutions (e.g., governmental agencies, commercial enterprises, families, voluntary associations, etc.).	For providers, understanding of their roles in the health and mental health care system. For consumer understanding of how to formulate their problems and where to go for what medical care, what to expect from different people in the institutions, etc.
The categorical order. Identifications of people by social stereotypes, such as class, race, ethnicity, occupation, personality typing, etc., and the corresponding behaviors.	Understanding and respect for differences in in-group and out-group valuations of characteristics and behaviors in these stereotypings.
The personal order. The linkages of persons in formal and informal relationships in "social networks."	Assessment of the individual's person strengths and resources, and understanding of interaction styles.
Use of Time (structuring of the day, week, seasons, year, life cycle). Time of interactions and flow of events.	

	Hours of Operations, accessibility of services, critical life events and periods.

FAMILY FORM

Structure of the Family (Genealogical Relationships recognized. Definition of statuses and roles.)	Identification of the patient's "family" and valued and devalued behaviors therein.
Functions of the family and roles therein. (Reciprocal rights and obligations of family members viz a viz one another in satisfaction of econmic, sexual, child rearing and companionship needs.)	Assessment and treatment of families. Understanding the developmental matrix of infancy and childhood and adult family adjustment.
Who marries whom under what circumstances (arranged vs. romantic marriages, consensual vs. legal unions, age of marriage, etc.)	Understanding of the in-group value placed on varying marital status and linkages and norms of marriage.
Residence patterns. Where and with whom or near whom does a couple live.	Understanding of family resources and tensions, household composition extended family network.
Conjugal roles. The marriage contract. Reciprocal roles of husband and wife (segregated, complementary, joint, etc.,	Understanding of the adjustment of couples and the varying ideal sex and other marital roles between groups.

PSYCHOSEXUAL DEVELOPMENT

Child rearing, practices, infant feeding, weaning, toilet training, sibling rivalry, socialization in adult roles, nature of "authority"	Assessment of "normality" of pscyhosexual development. Understanding variations from National norms in

discipline, education, rites of passage.	culture and personality.
Puberty (the definition or lack of definition of adolescence as a demarcated period. Expectations and model behaviors of the pubescent male and female. Changing roles.	Assessment of "normality" of adolescent adjustment. Understanding the stresses of adolescents under the conditions of rapid social change and cross-cultural contact and also across the generation gap.
Courting Patterns	Counseling of adolescents in this area of rapid social change and great cross-subcultural variation.
Adulthood Ideals and norms of adult behavior by sex, age, marital status, status in the family, socioeconomic category, other adult roles.	Establishing appropriate goals for therapy.

INTERACTION STYLES

Habitual patterns of interactional behavior, "polite" and "impolite" behaviors as differently perceived.	Establishing rapport, accurate communication, etc.

CONCEPTS OF ILLNESS

Folk concepts of disease Folk healing practices Culture-specific and culturally colored syndromes.	Understanding patient's presenting complaints and own understanding of the difficulties and resources and folk prescriptions for correction of those.

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Patterns of expression of complaints (e.g., somatization and psychologizing, over-statement and under-statement).	Accurate assessment of both organic and psychologically pathology.

COPING PATTERNS

Ideals of management of illness Traditional "Helpers" "Support System"	Understanding patient's resources for self-help, the folk healers' remedies that he may be using, and his expectations of the doctor. Understanding the patient's social matrix.

MANIFESTATIONS OF ILLNESS

(Epidemiology cross-culturally)

Differential rates and kinds of illness by geographic and social structural categories in differnt cultures and subcultures.	Relevant for all aspects of Medical Care.

Appendix D

January 15, 1986

Dear Colleague:

I am conducting a research project on the clinical judgments of social workers in the area of cross-cultural counseling with families. You have been selected from a random sample of Chicago area N.A.S.W. members. Enclosed you will find a two part questionnaire designed to provide empirical information on this most vital area.

The entire instrument has typically taken less than thirty minutes to complete. I am aware that this represents a considerable amount of time, given social workers' demanding schedules. However, I am asking you to invest this time so that we can better understand those important clinical decisions, which are so critical to the well-being of all of our clients.

The first section is simply an attempt to elicit basic demographic data. In the second section you will find a series of eight brief case vignettes. Following each case there are questions for you to indicate your professional opinion. Please complete all items in section A, before going on to complete section B. In addition, please use a ball point pen; as the data entry computer has been coded to read only red, blue or black ink.

Please note, that this is an independent (doctoral) social work study that is facilitated by N.A.S.W., but not sponsored by N.A.S.W. The return address envelope goes to the student researcher.

Thank you so much for your time and kind cooperation in this project. Should you desire an abstract of the results of this study, please indicate on your returned questionnaire.

Sincerely,

Janice Matthews, ACSW
Doctoral Candidate
Columbia University
School of Social Work

Appendix E

March 1, 1986

Dear Colleague:

In late January you received a questionnaire from me requesting you to respond to some demographic items as well as a series of case vignettes of families from different ethnic backgrounds. I am aware of the many and sometimes overwhelming professional demands that are placed upon social workers. However, I really need your support and sincerely appreciate the effort that it will take to complete and return the questionnaire I previously mailed.

Please be aware, that standard survey research procedure dictate that the sample be randomly selected (as you were). Furthermore, replacement of your valued participation with another social worker is also prohibited.

This letter is being sent to find out the status of the questionnaire sent to you. Your kind cooperation and effort is greatly appreciated!

Janice Matthews
Doctoral Candidate
Columbia University
School of Social Work

(PLEASE CHECK ALL THAT APPLY)

_ I DID receive the questionnaire

_ I did NOT receive the questionnaire

_ I have ALREADY completed and/or returned the questionnaire

_ I MISPLACED/LOST the questionnaire

_ I INTEND to return the questionnaire

_ I DO NOT intend to return the questionnaire

PLEASE RETURN THIS LETTER IN THE ENVELOPE PROVIDED.
THANK YOU!

Appendix F

March 18, 1986

Dear Colleague:

Thank you so much for responding to my letter inquiring as to the status of the "Ethnic Families" questionnaire that was originally mailed in late January.

You indicated on the returned form letter that you had not received this questionnaire. Enclosed you will find a replica of that instrument (and original cover letter), along with a pre-addressed stamped envelope for its return.

Your generosity and kindness in completing and returning this questionnaire is deeply appreciated. I feel this study to be a worthwhile endeavor that will yield important information.

I encourage you not to allow individual circumstances, such as: lack of involvement in "non-clinical" social work, degree earned, retirement status or years in the field to prevent you from participation in this study. On the contrary, the richness of this study will depend on the diversity of your professional circumstances.

Thank you again for your kind cooperation.

Janice Matthews
Doctoral Candidate
School of Social Work
Columbia University